

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
MEDICAID PURCHASING ADMINISTRATION  
Olympia, Washington**

**To:** All Providers  
Managed Care Organizations

**Memo #: 10-25**  
**Issued:** June 24, 2010

**From:** Douglas Porter, Assistant Secretary  
Medicaid Purchasing Administration  
(MPA)

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1-800-562-3022, option 2, or go to:  
<http://hrsa.dshs.wa.gov/contact/default.aspx>

**Supersedes Memo #: 01-13**

**Subject: Changes to WAC 388-502-0160 - Billing a Client**

The Department of Social and Health Services (the Department) revised WAC 388-502-0160, Billing a Client, effective May 27, 2010 as follows:

- Clarifying the requirements providers must satisfy before a Department client may be billed for healthcare services;
- Adopting a standard “Agreement to Pay for Healthcare Services form, DSHS 13-879”, that sets out a provider’s and client’s responsibilities when contracting for healthcare services that the Department may not pay for;
- Specifying the limited circumstances in which a fee-for-service or managed care client **may choose to self-pay** for healthcare services using the DSHS 13-879 form;
- Specifying the limited circumstances in which a **provider may bill** a fee-for-service client without a signed DSHS 13-879 form; and
- Identifying circumstances in which a **provider may not bill** a client even when the client has signed DSHS 13-879 form.

## **What Is Changing?**

**Effective for dates of service on and after May 27, 2010**, the Department implemented revisions to WAC 388-502-0160, Billing a Client, allowing providers to bill fee-for-service or managed care clients for covered healthcare services in limited circumstances, and allowing fee-for-service or managed care clients the option to self-pay for covered healthcare services.

Providers must fulfill certain requirements before services are provided. Providers who fail to do so may not bill clients for the services, even if the Department or a Department-contracted managed care organization (MCO) does not pay for the service.

Providers must accept payment by the Department or by a Department-contracted MCO as payment in full in accordance with 42 CFR 447.15. Balance billing is not permitted.

When contracting with clients for self-paid healthcare services, the Department requires providers to complete an Agreement to Pay for Healthcare Services form, DSHS 13-879:

- In accordance with all the described conditions and requirements, and
- Within 90 days before the covered or noncovered service is provided for which the client agrees to pay.

The revisions describe services a provider may not bill a client for under any circumstances. In addition to the transfer of certain medical records between providers these circumstances include missed appointments, shipping charges, concierge care, and price differentials for “upgraded” services.

**Why Does the Department Require a Signed Agreement to Pay for Healthcare Services Form, DSHS 13-789 When a Client Chooses to Self-Pay?**  
**[WAC 388-502-0160(2), (4), and (5)]**

The core provider agreement (CPA) requires providers to accept the Department’s payment for covered services as payment in full. Under the revised rules there are limited circumstances in which a provider may bill a client for covered or noncovered services. DSHS 13-879 form documents when these limited circumstances are met. The signed and completed form must be kept on file for 6 years in case of a Department audit.

For clients with limited English proficiency, the DSHS 13-879 form must be the version translated in the client's primary language. If necessary, this form must also be interpreted for the client. If the agreement is interpreted, the interpreter must also sign it. All other requirements for the DSHS 13-879 form apply.

The Agreement to Pay for Healthcare Services form, DSHS 13-879 (including translated versions) may be found at <http://www.dshs.wa.gov/msa/forms/eforms.html>.

## **What Must a Provider Verify?** **[WAC 388-502-0160(2)]**

Providers are responsible for verifying:

- The client is eligible to receive medical assistance services on the date that services are provided;
- Whether the client is enrolled with a Department-contracted managed care organization (MCO);
- Limitations on services within the scope of the eligible client's medical program (WAC 388-501-0050(4)(a) and 388-501-0065);
- The client is informed of the limitations on the specific service(s) requested;
- All applicable Department or Department-contracted MCO processes necessary to obtain authorization for the requested services are exhausted;
- That translation or interpretation is provided to clients with limited English proficiency (LEP) who agree to be billed for services; and
- That all Department or Department-contracted MCO requirements have been fulfilled. The provider must keep on file all documentation proving fulfillment of those requirements.

## **When Must a Provider Use the DSHS 13-879 form to Bill a Client Who Chooses to Self-Pay for Services?** **[WAC 388-502-0160(1)(a) and WAC 388-502-0160(5)(a)(vii) through(ix)]**

Upon completing the DSHS 13-879 form, fee-for-service or managed care clients may choose to self-pay for healthcare services and providers may bill those clients in the following limited circumstances:

- The service is not covered by the Department, the client is informed of his or her right to request an exception to rule (ETR), and the client chooses not to ask the Department for an ETR;
- The service is not covered by the Department, the client requests an ETR and the ETR process is exhausted, and the Department denies the service;

**Note:** The ETR process is available only for services that are identified as noncovered in WAC 388-501-0070 or specific program WAC. Covered services, including those with limitations, may be subject to prior authorization (WAC 388-501-0165.)

- The service is covered by the Department with prior authorization, all the requirements for obtaining authorization are completed, the client completes the administrative hearings process or chooses to forego it or any part of it, and the service remains denied by the Department as not medically necessary; or
- The service is covered by the Department and does not require authorization, but the service is a specific type of treatment, supply, or equipment based on personal preference that the Department does not pay for. The client completes the administrative hearings process or chooses to forego it or any part of it.

**Note:** The client and provider are required to sign and date the DSHS 13-879 form *before* the service is provided, but no more than 90 days before. If more than 90 days have elapsed since the DSHS form was completed and the requested service still has not been provided, a new DSHS form must be completed and signed by the provider and client.

To download and print Department/MPA forms, go to the Department/MPA website at: <http://www.dshs.wa.gov/msa/forms/eforms.html>.

### **What Must a Provider Do to Bill a Client for Healthcare Services When the DSHS 13-879 form is Required?**

**[WAC 388-502-0160(2) through (5)]**

To bill a client who chooses to self-pay in the limited circumstances described in the section of this memo directly above, a provider must complete the DSHS 13-879 form and ensure that all of the following requirements are met:

- The provider fulfills all responsibilities set forth in WAC 388-502-0160(2);
- All the conditions for obtaining Department or Department-contracted MCO payment are satisfied (i.e., a provider cannot bill a client if a request for services is denied because the provider did not follow the applicable rules, billing instructions, or billing requirements);
- The provider submits all information necessary to obtain authorization of a requested covered service from the Department or Department-contracted MCO and the service remains denied;
- The provider submits all information necessary to obtain an ETR, if the client chooses to pursue one, for a requested noncovered service and the service remains denied by the Department or the Department-contracted MCO;
- The client completes or chooses to forego the administrative hearings process and the requested service remains denied by the Department or the Department-contracted MCO;

- The provider and the client (and, if necessary, an interpreter) who chooses to pay for the requested service(s) complete the DSHS 13-879 form;
- The provider ensures that a translated (and, if necessary, interpreted) DSHS 13-879 form is completed by and with clients with limited English proficiency who choose to pay for the requested service(s);
- The requested service is one for which a provider may bill a client (i.e., it is not listed in WAC 388-502-0160(9)); and
- The provider fully informs the client of any covered healthcare service options that may be available in lieu of the requested service for which the client is choosing to pay.

### **When May a Provider Bill a Client Without A DSHS 13-879 form Signed By The Client?**

**[WAC 388-502-0160(6)]**

The following are limited circumstances in which a provider may bill a client without completing a DSHS 13-879 form with the client:

- The client, the client's legal guardian, or the client's legal representative:
  - ✓ Was reimbursed for the service directly by a third party (see WAC 388-501-0200); or
  - ✓ Refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill the third party insurance carrier for the service.
- The client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a medical assistance program. In this circumstance, the provider must:
  - ✓ Keep documentation of the client's declaration of medical coverage. The client's declaration must be signed and dated by the client, the client's legal guardian, or the client's legal representative; and
  - ✓ Give a signed copy of the DSHS 13-879 form to the client and keep the original on file for 6 years from the date of service, for Department review upon request.
- The bill counts toward the financial obligation of the client or applicant (such as spenddown liability, client participation as described in WAC 388-513-1380, emergency medical expense requirement, deductible, or copayment required by the Department.)

**Note:** An individual who has applied for medical assistance coverage under the medically needy (MN) program is required to:

- Spenddown excess income on healthcare expenses to be eligible for MN coverage; and
- Have healthcare expenses greater than or equal to the amount that the client must spenddown.

The provider must not bill the client for amounts in excess of the spenddown liability assigned to the bill. (Chapter 388-519 WAC)

- The client is under the Department's or a Department-contracted MCO's patient review and coordination (PRC) program (WAC 388-501-0135) and receives nonemergency services from providers or healthcare facilities other than those to whom the client is assigned or referred under the PRC program.

**Note:** If the client is identified as assigned to the PRC program, this means the Department or a Department-contracted MCO has determined the client over used or inappropriately used healthcare services. In order for an unassigned provider to receive payment from the Department or a Department-contracted MCO, the provider must receive a referral from the PRC client's assigned primary care provider. The client's primary care provider manages and coordinates all of the client's care, including referrals to specialists and other healthcare providers.

- The client is a dual-eligible client with Medicare Part D coverage or similar creditable prescription drug coverage and the conditions of WAC 388-530-7700(2)(a)(iii) are met;
- The services were provided to a TAKE CHARGE or Family Planning Only client, and the services are not within the scope of the client's benefit package;
- The services were noncovered ambulance services. This applies specifically in non-fatal situations when a client was treated by ambulance staff at the scene, but not transported (WAC 388-546-0250(2));
- A fee-for-service client chooses to receive nonemergency services from a provider who is not contracted with the Department after the provider informs the client that he or she is not contracted with the Department and that the services offered will not be paid by the client's healthcare program;
- A Department-contracted MCO enrollee chooses to receive nonemergency services from providers outside of the MCO's network without authorization from the MCO (i.e., a nonparticipating provider); and
- The requested service is one for which a provider may bill a client (i.e., it is not listed in WAC 388-502-0160(9)).

**When Is a Provider *NOT* Allowed to Bill a Client?**  
**[WAC 388-502-0160(4), and (7) through (9)]**

Regardless of a signed DSHS 13-879 form, a provider must not bill a client for:

- Services for which the provider failed to satisfy the conditions of payment described in:
  - ✓ Department rules;
  - ✓ Department fee-for-service billing instructions; and
  - ✓ Requirements for billing the Department-contracted MCO with whom the client is enrolled.
- Services for which the provider has not received payment from the Department or the client's MCO because the provider did not complete all requirements necessary to obtain payment;
- Services for which the Department denied authorization because the required information was not received by the Department. (WAC 388-501-0165(7)(c)(i))
- Copying, printing, or otherwise transferring healthcare information, as the term healthcare information is defined in chapter 70.02 RCW, to another healthcare provider, which includes, but is not limited to:
  - ✓ Medical/dental charts;
  - ✓ Radiological or imaging films; and
  - ✓ Laboratory or other diagnostic test results;
- Missed, cancelled, or late appointments;
- Shipping and/or postage charges;
- "Boutique," "concierge," or enhanced service packages (e.g., newsletters, 24/7 access to provider, health seminars) as a condition for access to care; or
- The cost difference between an authorized service or item and an "upgraded" service or item (e.g., a wheelchair with more features; brand name versus generic drugs).

**Note:** The Centers for Medicare and Medicaid Services (CMS), the federal agency which oversees all state medical assistance programs, has provided clear guidance that billing for “no-shows” is not allowed. This policy is based on the reasoning that missed appointments are not distinct reimbursable services, but a part of providers’ overall cost of doing business. The Medicaid rate is assumed to cover the cost of doing business, and providers may not impose separate charges on clients. The same is true for copying and shipping costs. “Balance billing” for “upgraded” services is specifically prohibited by 42 CFR § 447.15.

### **When Must a Provider Refund the Full Amount Received from a Client as Payment for a Healthcare Service?** **[WAC 388-502-0160(2), (4), and (7)]**

There are situations when a provider must refund the full amount of a payment previously received from or on behalf of an individual and then bill the Department for covered services provided. In these situations, the individual becomes eligible for a covered service that had already been furnished. Providers must then accept as payment in full the amount paid by the Department or managed care organization (MCO) for healthcare services furnished to clients.

A provider **must** refund a client’s payment when:

- The individual was not receiving medical assistance on the day the service was furnished, and paid as a private pay patient. The individual applies for medical assistance later in the same month in which the service was provided and the Department makes the individual eligible for medical assistance from the first day of that month;
- The client receives a delayed certification, as defined in WAC 388-500-0005, for medical assistance; or
- The client receives a certification for medical assistance for a retroactive period according to 42 CFR § 435.914(a) and defined in WAC 388-500-0005.

A provider **must** also refund a client’s payment when:

- The amount billed by a provider and paid by a client is in excess of the spenddown liability assigned to the bill (Chapter 388-519 WAC); or
- The provider has not complied with the applicable requirements of WAC 388-502-0160 before billing a client for services and receiving payment from the client.

For specific information please refer to the *ProviderOne Billing and Resource Guide* available online at: [http://hrsa.dshs.wa.gov/download/ProviderOne\\_Billing\\_and\\_Resource\\_Guide.html](http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html).

## **How Can I Get the Department/MPA Provider Documents?**

To download and print the Department/MPA provider numbered memos and billing instructions, go to the Department/MPA website at <http://hrsa.dshs.wa.gov> (click the ***Billing Instructions and Numbered Memorandum*** link).